DMS Lympstone

Quality report

Commando Training Centre Royal Marines (CTCRM)
Lympstone
Exmouth
Devon
EX8 5AR

Date of inspection:
28 November 2019

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found as part of the inspection and information given to us by the practice.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Requires improvement

Chief Inspector's Summary

We carried out an announced comprehensive inspection of DMS Lympstone on 19 July 2018. The practice was rated as good overall, with a rating of requires improvement for the safe domain. The effective, caring, responsive and well-led domains were rated as good.

This announced follow up inspection was undertaken on 28 November 2019. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

As a result of this inspection the practice is rated as good overall

The key question followed up as part of this inspection is rated as:

Are services safe? – good

Are services effective – requires improvement

A copy of the reports from the previous inspection can be found at:

http://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#army

Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of follow-up inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The practice delivered high quality emergency care. It had a well-practised response to emergencies and this was regularly tested both in training and in real life saving scenarios. New monitoring equipment was in place that is fit for purpose and essential for the appropriate treatment of patients with exertional heat illness. We noted that not all equipment used within the resuscitation room was fit for purpose.
- Patients notes were up to date with Read coding accurately reflecting the current needs of the patient population.
- A minor operations audit has been undertaken in line with NICE guidelines.
- Formal governance arrangements have begun to ensure that staff deliver care in line with Defence Primary Healthcare (DPHC) Standard Operating Procedures.

Notable Practice

- A bespoke template had been introduced which detailed the complete patient care pathway following admission for resuscitation. This document went with the patient if they were admitted to hospital to ensure up to date information was available.

The Chief Inspector recommends:

- Ensure all mandatory staff training is up to date.
- DPHC should review staffing requirements to ensure there are sufficient staff with the right skills and experience to deliver both primary care and PHEC (Pre-Hospital Emergency Care).
- Locum inductions should include information bespoke to the practice.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection was undertaken by a CQC inspector and a GP specialist advisor.

Background to DMS Lympstone

DMS Lympstone known as the Commando Training Centre Royal Marines (CTCRM) delivers all Phase 1 (initial), Phase 2 (continuation) and career course/specialist training to Royal Marines and Officers including initial training of the Royal Marines Band. All training is conducted under the Office for Standards in Education, Children's Services and Skills (OFSTED) auspices and is continually assured by internal and external agencies.

CTCRM provides the full spectrum of primary and intermediate health care for all entitled service personnel from all three services, and occupational care to entitled reservists across the South West region. CTCRM contains its own 20 bed low dependency ward staffed by registered nurses 24 hours a day, an X-ray department with reporting radiographer, a physiotherapy department dispensary and a large complex injury rehabilitation department.

There are no registered dependents and currently a small population of under 18-year olds. The majority of the patient population are aged between 16 and 55 with a small number outside this range. There is a high turnover of the patient population, which on the day of the inspection was approximately 2,000.

The Primary Care Rehabilitation Facility (PCRF) comprises both clinical rooms in the practice, and the larger ‘Hunter Gym’ which is approximately three minutes’ walk away. The Hunter gym hosted rehabilitation for Hunter troop; these are Royal Marines that are injured who temporarily join this troop to undergo a programme of rehabilitation before rejoining training and being prepared for front line combat duties.

Family planning advice is available within the practice and maternity and midwifery services are provided by NHS practices and community teams. Mental Health referrals are made to Department of Community Mental Health at HMS Drake located approximately 50 miles away.

The practice is open Monday to Friday 07:00 to 16:30 hours. The practice is staffed 24 hours a day seven days a week by a duty medic and ward nurse, with a doctor and medic on call for emergencies. Outside of these times, patients were referred to NHS 111 or local out of hours’ services.

The staff team

Position	Numbers
Senior Medical Officer (SMO)	one
Civilian medical practitioners (CMP)	one (covered by two locums)
Military Medical Officer (MO)	one
Senior Nursing Officer (SNO)	one
Practice nurses	five
Practice manager	one
Deputy practice manager	one
Administrative staff	four
Pharmacy technicians	one
Physiotherapists	four

Are services safe? — Good

We rated the practice as good for providing safe services.

Following our initial inspection the safe domain was rated as requires improvement for providing safe services. We made the following recommendations:

- Ensure all medical equipment is fit for purpose.
- Formal arrangements should be in place ensuring that staff deliver care in line with Defence Primary Healthcare Policy (DPHC).

From this follow up inspection, we found the recommendations made previously had been met.

Risks to patients

- At our previous inspection we saw the practice was committed to the care and well-being of their patients, responding immediately when an emergency arose. However, when managing acute injuries, such as heat illness, the practice was working to its own bespoke policy that had been ratified by the local hospital, but this was not consistent with DPHC Standard Operating Procedures (SoPs).
- Following our inspection, we raised this issue with DPHC, and in response they arranged a visit to the practice by an Emergency Medicine Consultant to make an initial assessment on patient safety. They found the practice had been providing 'active cooling' to what they maintained was best practice for rapid cooling – namely partial immersion in cold water/ice. They were doing so on a verbal recommendation from the Institute of Naval Medicine. As we had previously seen, this approach was outlined in their own bespoke policy but did not reflect DPHC SoPs. The interim decision made by DPHC was to continue as emergency care was not unsafe. A formal review of practice was recommended.
- Since our initial inspection, the practice has developed a protocol around the management of heat/climatic injuries which had been agreed by the Defence Consultant Advisor in Pre-Hospital Emergency Medicine (DCA PHEM). This was printed onto large posters and displayed in the resuscitation room. To date no changes have been made to the policy (Heat Illness and Cold Injury, Prevention and Management) although audit work was underway, and the Heat Illness Working Group was considering policy changes.
- At this inspection we saw improvement in the management of emergency care delivery with new equipment and protocols in place. A recent audit (January – November 2019) showed the

total number of Exertional Heat Illness (EHI) casualty incidents that had occurred was 35 with six confirmed as heat stroke.

- Since the last inspection, Defence Primary Healthcare (DPHC) had supplied the practice with five Tempus Pro medical monitors. These are waterproof patient monitoring devices that are used in the resuscitation department at the practice but could also be taken out on exercise. Alongside this, the base has funded four 'Polar Pods' and had trialled their use. These are mobile cooling stations specifically designed to allow effective Ice-Cold Water Immersion (ICWI), and safely cool a person's body core to a safe, comfortable temperature. They had proved effective and mitigated the need for ice cold water immersion both within the resuscitation department and in the field.
- Since the last inspection the medical centre had been supplied with two NHS ambulances to collect patients from the training areas. These vehicles were appropriate and fully kitted out for the provision of Pre-Hospital Emergency Care on Exercises.
- The Chain of Command (CoC) had been very supportive in working in partnership with the practice to reduce the risk of EHI in training and managing EHI casualties. The base had reviewed and updated their Training Standing Orders for speed marches following consultation with the doctors.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. For example, all information taken from the monitoring devices was printed out and scanned onto the electronic patient record system (referred to as DMICP) following the emergency.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. We saw regular communication with the consultant at the local NHS Emergency Department around the best care for patients who were acutely ill with heat injuries. Decisions to admit to the NHS hospital were made by doctors on an individual case basis. Patients admitted had with them a full summary of the emergency care they had received including read outs from the monitoring devices which showed all their vital observations. This information was recorded on a bespoke assessment form that had been devised by the practice.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had access to the system. Staff provided several examples of significant events they had raised demonstrating there was a culture of effectively reporting incidents. ASERs were a standing agenda item at the weekly practice meeting and these were minuted. We saw evidence that showed the practice had raised 17 significant events from November 2018 to October 2019. A comparison of incident types had been conducted and no trends were identified. Whilst we saw good staff knowledge and an open culture towards incident reporting we did find that some incidents were missing the appropriate detail to enable full opportunity for further learning.

Are services effective?	Requires improvement

We rated the practice as requires improvement for providing effective services.

At our previous inspection, we rated the practice as good overall for providing effective services. However, there were some gaps in the provision of effective services including: staff induction, the use of appropriate Read Codes and the need for a minor surgery audit.

We made the following recommendations:

- Ensure patients notes are up to date in respect of read coding being accurate to reflect the current needs of the patient population.
- Ensure a minor operations audit is undertaken in line with NICE guidelines.
- Ensure that all staff are appropriately trained by completing all inductions.

From this follow up inspection, we found the recommendations made previously had been met. We did however find some further issues requiring improvement. Following our review of the evidence provided, the practice is rated as requires improvement for providing effective services.

Monitoring care and treatment

The practice used data collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.

- The lead nurse was responsible for overseeing the management, including recall, of patients with long term conditions. They carried out regular searches, recalling patients when appropriate. We looked at a selection of patient records and were assured that clinicians were consistent in how patients were reviewed with the appropriate coding used.
- We looked at a range of clinical records and were assured that the care of patients with a mental illness and/or related symptoms was being effectively and safely managed. Appropriate coding and templates were used to assess patients and plan their care.
- The practice had undertaken an audit of minor surgery outcomes in November 2019. The outcomes showed that none of the staff qualified to undertake minor surgery were up to date with IPC and therefore patients could not be assured they were effectively protected from infection. As a result no further minor surgery was undertaken until all staff were adequately trained to do so. All patients requiring minor surgery were referred to HMS Drake Medical Centre. Following the inspection the practice confirmed that all staff were now up to date with IPC training.

Effective staffing

- A generic and role-specific induction was in place for permanent staff new to the practice. However, there was no bespoke induction for locum staff. The practice manager confirmed this would be undertaken following the inspection.
- Although mandated training was monitored, we noted that not all the practice staff team were in-date for all required training. For example, two staff were out of date for IPC training, nine

staff were out of date for level 2 Caldicott training (The Caldicott Principles are fundamentals that organisations should follow to protect any information that could identify a patient, such as their name and their records).

- There were four doctor posts at the practice. When fully staffed and trained this was adequate to provide safe pre-hospital care for the duration of the working day. At least one of the three military doctor posts had been vacant for 38 out of the last 68 months. Whilst locum doctors had been able to partially fill these gaps, the locums were not suitably qualified to provide emergency care.
- One doctor was trained to a level 6 Suitable Qualified and Experienced Person (SQEP) and was the nominated lead for PHEC. That doctor deployed on the 30 mile march every two weeks during the high-risk heat period. There was no contingency plan should this doctor be absent for any length of time. There was potential for this to delay or prevent operational exercises.
- A comprehensive training programme was conducted prior to the high-risk period to all staff. This included theory discussions, small group sessions and practical scenarios. Formal assessments of doctors in the management of EHI casualties was conducted by a qualified doctor to assess competency in managing the full spectrum of EHI casualties from heat exhaustion to heat stroke. Royal College of Emergency Medicine (RCEM) assessment forms were completed for each individual to include in their annual GP appraisals. Two out of the four current doctors had been signed off as competent in managing the full spectrum of EHI. We noted that three out of four doctors were out of date in Advanced Life Support training.